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Original Lectures.

*THE OPENING EXERCISES OF THE POST-GRADUATE COURSE FOR 1887.**

EXTRACTS FROM SOME OF THE SPEECHES MADE ON THIS OCCASION IN THE HAHNEMANN HOSPITAL AMPHITHEATRE ON TUESDAY EVENING, APRIL 5, 1887.

The post-graduate course of the Hahnemann Medical College and Hospital of Chicago, for the current year, was inaugurated in the amphitheatre of the hospital on Tuesday evening, April 5. The audience consisted of a large number of physicians, medical students and visitors. The exercises consisted of a number of speeches and addresses, of which the following is a condensed report:

THE PRESIDENT, DR. D. S. SMITH, spoke first of the valuable services which his predecessor, the late Dr. A. E. Small, had rendered to the cause of homœopathy in general, and to this college in particular. For more than a quarter of a century he had labored in these halls as a teacher, and those who had enjoyed the privilege of listening to him would never cease to respect his memory.

He then welcomed the class and commended the opportunities awaiting them in the course now to be opened. The advantages offered were far superior to what they had had in private practice; the chairs were filled by able and competent teachers, and doubtless they would profit greatly by what they should see and hear.

*We present a brief report of this event in lieu of the usual clinical lecture.

There are good and reputable colleges of our school east and elsewhere, schools that are manned by learned and eminent professors, but it is meet and proper that the "Old Hahnemann" should take the lead in establishing and maintaining a post-graduate course of instruction for physicians. An eminent and distinguished teacher and author had told him plainly that Chicago was the teaching center for homœopathy in this country, and the success of this college and all that belongs to it is evidence of the fact.

A little more than forty years ago but one homœopathic physician could be found between the lakes and the Pacific coast, but now every town and village in that vast domain has one or more practitioners of our school. This very college has more than *fifteen hundred graduates*, most of whom are scattered through that region, and who are busy and useful to an extraordinary degree. These alumni are progressive and aggressive; they spread the truth of homœopathy far and wide, and bring its blessed influences to bear upon the needs of the sick and the suffering wherever they are found.

He was not ashamed of the title of homœopathist, more especially since this Hahnemann College and Hospital has done, and is still doing such a noble work in fitting its pupils for a life of usefulness and honor. We need specialists, such as oculists and aurists and surgeons and gynecologists. A homœopathist is a specialist in therapeutics, a fact which accounts for his superior skill and success in curing disease. He knows enough to keep all harmful and poisonous drugs away, for he endorses the sentiment of Dr. Oliver Wendell Holmes, (the unwitting and unwilling apostle of homœopathy) when he says: "Throw out opium; throw out a few specifics, which our art did not discover; throw out wine, which is food, and the vapors of which produce the miracles of anæsthesia, and I believe the whole materia medica as now used could be sunk to the bottom of the sea, and it would be better for mankind, but worse for the fishes."

THE OBJECT AND PURPOSE OF THE POST-GRADUATE COURSE IN THIS COLLEGE AND HOSPITAL.—PROF. LUDLAM said that the committee which had arranged the programme for the evening

had assigned him this subject, and that he would call the attention of the class to a few valid reasons why this course had been instituted.

1. *To compensate the doctor for some of the defects of his college course.* Nobody knows better than the earnest teacher what are the shortcomings of the usual winter term of instruction in our medical schools. In the brief space of time allotted, no matter how faithful and conscientious the professor may be, the numerous branches of a sound medical education can not be adequately or thoroughly taught.

In many cases, especially since our colleges are multiplying so rapidly, the teachers themselves are not men of learning and experience, and must of necessity fail to place the proper emphasis upon their instruction. The pupil has no test for distinguishing the practical from the theoretical, and it is a thousand chances to one if he does not retain what he should reject and forget. And when he goes into the field of practice with a false and imperfect knowledge of what will be expected of him he will feel himself but poorly equipped for his life work. He crammed for the degree and got it, but in so doing he failed to lay up a stock of resources of which he now finds himself greatly in need. So that, if he settles in a wide-awake community, if the professional competition is active, or if he stands as the sole representative of our school of medicine, he may fall behind in the race, unless he can in some such way indemnify himself for what he lost or overlooked while he was in college.

2. *To help him to develop such tastes and gifts in medicine and surgery as he may have discovered in the field of practice since he left college.*—It does not always accord with the fitness of things if a student determines to follow some particular line of professional work before he has had his first patient. The bias toward certain branches is often referable to the popularity and the enthusiasm of the teacher, or the local reputation of the preceptor. Before graduation the majority of medical students, the world over, resolve to become surgeons, but when they have tested the matter they will change their minds. From force of circumstances the most of them

become general practitioners, and plow along faithfully and honorably through the field of duty that lies before them. In time, however, by a process of practical evolution, a certain share of them will discover that their tastes, ideas and inclinations, as well as the results obtained from their labors, point in a certain direction and indicate most decidedly that it is their duty to cultivate a growing fondness and adaptation for certain special lines of practice.

Now it is for the purpose of giving these supplementary advantages to those who are inclined, that this course has been established. It is the old story of setting the hoe to find the handle. Hence the variety of studies that are offered, all of them with a bedside bearing that the earnest, diligent and progressive doctor cannot fail to appreciate.

3. *To draw a focus on clinical work to the exclusion of impracticable theories, and of wordy and wasteful topics of all kinds.*—What kind of knowledge is of most worth is a question that comes home to the practitioner with peculiar emphasis. If he has been studious and faithful, his power of concentration and his fondness for what is practical are sure to be developed; and with this growth will come a desire and a determination to avail himself of such advantages as will bring the very best results. Manifestly, a course of instruction which is almost wholly clinical and objective, short, sharp and practical to the last degree; one in which the various branches are set forth and emphasized by teachers whose thoughts and words and lessons are rooted in experience, is exactly what is needed by many of our physicians. And I am sure that you will not fail to draw a focus on very much that is valuable in the term which will open to-morrow morning.

THE SURGICAL CLINIC.—PROF. G. A. HALL said: In responding for the chair of surgery, it affords me great pleasure to stand here as the representative of that department in the Hahnemann College and Hospital.

In the early history of medicine the practice of surgery was confined exclusively to the barbers, bathers and gymnasts, until the time of the Alexandrian school, when it was coupled

with the practice of medicine. As colleges were founded, the chair of surgery became a prominent part of the curriculum.

During the early days of the homœopathic colleges this branch was poorly represented as there were few of that school who made that a specialty. Many of us who graduated at that time were obliged to receive our surgical education in Allopathic institutions, and there was a time when the homœopath gave himself up so exclusively to the study and the practice of medicine, according to the law of similars, that all surgical cases were given to those of the old school, who made that a special study. This is, however, not true of the present day. We can now enumerate by the hundreds those of our school who not only practice it, but who have risen to eminence in this line of work. The reports which come from many of the alumni of this college, ring with progress in this department.

The Hahnemann Hospital is exclusively under the control of this faculty, and is not subject to the fluctuations so embarrassing in hospitals controlled by non-medical politicians. In these institutions a large number of patients may pass before the eye of the student, who is simply permitted to look down upon them from a dizzy height and catch an imperfect glimpse of the operation. But while we have a smaller number of patients, we have all of the more important and intricate operations. We desire also to give the student the benefit of the operations and of the subsequent dressings and treatment as well, hoping thereby that he may be better able to assume such duties for himself.

We are pleased to see so many at the opening of this post-graduate course, and we assure you that it will be our aim to have each one of you gain every possible advantage from this clinical amphitheatre. We shall invite you to make personal examinations of rare and difficult cases for the purpose of accurate diagnosis, and so far as possible we shall allow you to participate in the various major operations.

We feel confident that with the assurance of material promised, our clinics will not prove uninteresting either in the number or the variety of cases.

THE ORTHOPŒDIC CLINIC.—PROF. SHEARS spoke for this section of the Surgical Department as follows: As you have learned from the remarks of my colleague, Prof. Hall, our orthopœdic clinic is of rather recent formation. Do not understand me that orthopœdics have not been taught in this college, nor cases of deformity been treated in this amphitheatre, but that, previous to the present year these cases were treated in the general surgical clinic. With the growth of that clinic it became imperative, unless a whole day were to be devoted to surgical cases, that the clinic be divided. It was thought best, therefore, at our last session to establish a separate clinic for the consideration and treatment of deformities. Although this clinic may be looked upon as the result of an overflow of the general clinic it is none the less an important one. It takes cognizance of a class of cases that are of especial interest to the surgeon, both because of their great number and because of the comparatively small amount of attention which has been devoted to this division of surgery. That malformations and deformities are frequent is a proposition easily verified by a walk through the crowded streets of our city. Even in the smaller towns and hamlets it is not an unfrequent occurrence to meet one whose whole life has been made bitter because he is different from his fellows, or whose usefulness has been impaired by some unsightly malformation. Many of these cases might have been different had they been treated by the methods of the surgeons of the present day. It cannot be denied that until within the last few years the subject of orthopædics has not received that attention which from its importance it deserved. Many of the colleges, while they announce special lectures on eye diseases and ear diseases and throat diseases and skin diseases, make no mention of special lectures or clinics in the consideration or treatment of deformities. The practitioner himself is inclined to leave the treatment, with the possible exception of dividing a tendon, to the mechanic and maker of instruments. One pleasant feature of orthopædic work is that, unlike many other divisions of surgery, one is not obliged to mutilate in order to benefit his patient. The contracted limb is freed, the distorted form restored to

symmetry without the loss of a single tissue and almost without the loss of a single drop of blood.

In conducting the clinic it will be my aim to so present the cases that you may become thoroughly familiar with their essential characteristics, remembering, as has been said by Prof. Ludlam, that benefit from clinical work does not always depend upon the number of cases brought before the class, but upon the manner in which the salient points of the case are presented. A few cases thoroughly studied, their likenesses compared, their differences noted, and the necessary inferences drawn may result in more benefit to the student than a hundred cases hastily and imperfectly considered. In the study of the cases I suggest to you that you adopt a plan which I have followed with excellent results, to make your diagnosis and determine upon your line of treatment before the one conducting the clinic has announced his views. In this manner you are made an active rather than a passive agent, and have all the benefit that would accrue were the patient your own and were the responsibility on your own shoulders. In conclusion let me say that we shall be glad to have you send to the clinic any cases that may come to your notice during your stay with us, or after you have gone to your homes.

Prof. Fellows—The remarks of my colleague, the dean of the faculty, concerning the condition of the graduates from the medical colleges reminds me of an anecdote told me by a friend of the late William Travers, of New York. He was dining at a table one day where a certain man had been dilating somewhat largely on what he had achieved in life. To emphasize his importance and have it duly impressed upon the memory of his auditors, he wound up his talk with a statement, made in a very positive manner, that he was a self-made man. Travers with his infinite good humor instantly replied:

"Wh-wh-why didn't yo-yo-you put so-so-some hair on yo-yo-your head?" The man was bald.

Students go from college not always quite finished off, and it is the object of this post-graduate course of lectures to give

them a chance to get the finishing touches applied—to get the proper amount of hair on their professional heads.

In speaking for the Chair of Theory and Practice I wish to say, that it is the intention of the occupant to make the teaching thoroughly practical and clinical. It will be the aim in the clinic of nervous diseases to so analyze the symptoms as to trace them, so far as is practicable, to their ultimate cause, as well as to study them in their various combinations. It will be thus that a diagnosis of the condition of the patient will be arrived at, not such a diagnosis as will simply enable us to name the disease, but such a one as will enable us to appreciate what pathological processes are going on in the patient's system, and which will point out the proper lines of treatment and prognosis in the case.

The amount of clinical material at our command will not only make it possible to show you the common forms of this class of diseases, but many of the rarer forms.

The clinic of physical diagnosis will be under the able charge of Prof. Crawford, who will give the practitioners every opportunity to examine the cases individually, and discuss with them the signs and symptoms of the disease, tracing out the meaning of each departure from normal conditions, comparing them, and finally summing up their indications for treatment. I promise you a rich treat from this Chair, where there is more danger of having too little time to utilize the abundant material than a lack of material for illustrating the different diseased conditions that will come under the professor's observation.

Other speeches followed. Prof. Gilman responded for the department of Clinical Hygiene, and Prof. King for that of Clinical Chemistry. Because of a severe influenza Prof. Hawkes was excused from speaking on behalf of the Medical Clinic. And thus the post-graduate course for 1887 was opened with the most cheering and encouraging prospects, and with great good feeling all around.

Clinical Society Transactions.

DR. A. K. CRAWFORD, SECRETARY.

APRIL MEETING, 1887.

The regular monthly session of this Society took place on Saturday evening, April 9, at the Grand Pacific Hotel, in Parlor 44. In the absence of the President, Dr. G. F. Shears occupied the chair. The nomination and election of a few new members was attended to, after which the Chair called for

THE REPORT OF THE BUREAU OF SURGERY.

DR. G. A. HALL, CHAIRMAN.

HAHNEMANN HOSPITAL SURGERY.—Believing that it might prove interesting to the members of the Clinical Society, I have concluded to give a summary report of the surgical clinics of the Hahnemann Hospital for the year ending March 1, 1887.

In rendering this report I desire in no manner to make invidious distinctions, nor shall I attempt to give in detail each and every case as it appears upon the clinic book. After making these general statements, I will give in particular a few of the more important cases which have come before the class.

In the surgical department of Hahnemann Hospital there have appeared 305 surgical cases, all of which underwent operation and treatment. Included in this number may be enumerated nearly every capital operation known in the art of surgery. The following is a list of the most important: gastrotomy; lithotomy; radical cure for hernia; radical cures for hydrocele and castration; excision of superior and inferior

maxillary; excision of one-half of the left innominate bone; excision of the tongue; resection of the fore-arm; resection of hip; ancient and recent fractures; operations for torticollis and talipes; caries of tibia and femur; amputation of upper and lower extremities; removal of mammary glands for carcinoma and sarcoma; removal of epithelioma of the lip and tongue; extirpation of parotid sub-maxillary and sub-lingual glands; removal of rectum; operation for harelip and staphylorraphy, and last of all, the extraction of a full under set of teeth from the cardiac orifice of the stomach.

Out of the 305 cases there have occurred only two deaths. The first was from suppurative cystitis and carcinoma of the prostate gland; the second was after gastrotomy for carcinoma of the stomach. Aside from these 305 cases there have been applied by the house surgeon and hospital staff at the morning sub-clinics 2,184 surgical dressings.

The regular surgical clinic on Monday has occupied from three to four hours daily and on Tuesday afternoon one hour has been devoted to orthopedic surgery. This with the six hours of sub-clinic work makes in all ten hours each week or in twenty weeks, 200 hours, of solid clinical work. Add to this the clinics and sub-clinics out of the session gives 488 hours for the entire clinical work of the year.

In giving these figures we may not compete with larger institutions but I feel that we may justly claim that there is no hospital which can offer a better record for the same length of time and number of cases.

These cases are all under the immediate control of the surgical department of the college and hospital and all material is utilized to the best advantage and for the best interest of those who desire to study surgery.

The following cases are given as samples of the term work:

Case 1.—Mr. B., æt. forty-five, sallow in complexion, of slight build, with gray eyes and dark hair, had suffered with hip joint disease for years. When about fifteen years old he began to suffer in his left hip. Inflammation and suppuration of the cotyloid cavity followed. This was partially controlled for a time. Subsequently, however, after exposure

and injury, there was renewed inflammation and suppuration, from which he was never after free. The entire joint and the femur as well became so diseased that an amputation at the hip joint was performed about two years ago.

December 13, 1886, he entered the hospital for treatment. Several sinuses were found which were discharging pus. A rectal examination being made we were convinced that ulceration had destroyed the base of the cotyloid cavity. A crucial incision was made, giving an opening down to the base of the cavity, which was found in a deplorable condition. In every direction from the cotyloid cavity the innominate bone was honey-combed and undergoing slow disintegration from ulceration. By means of the chisel and gouge we cleaned out the diseased parts until we reached healthy bone tissue. When this was found a greater portion of the innominate bone had been removed. The sinuses were then scraped out, the flaps were brought together and retained by silver wire sutures. Gauze saturated in carbolated glycerine was applied over the wound, the same being carefully protected with cotton and bandage.

For forty-eight hours the patient suffered greatly from the effects of the anæsthetic. After this his appetite returned, and for three weeks he improved rapidly, continually taking on flesh. A harrassing cough which had annoyed him for many months gradually subsided. The fourth week he began to have chills and rise of temperature. An abscess formed in the pelvic cavity and discharged per rectum. By the use of rectal suppositories and injection of carbolic acid dilute, the abscess healed. Believing now that our patient would do better in a quiet country home we advised his removal.

The features of this case are: 1st. The long continuance of this disease, which is the rare exception. Ninety per cent of the victims of hip joint disease die before the age of twenty.

2d. We believe if the limb had been amputated at an earlier period, or if, when it was amputated, all the diseased bone in and about the cotyloid cavity had been removed, the patient's life might have been saved.

3d. We wish to note the marked improvement in the cough after our operation. This is a feature which I have often noticed in the removal of diseased bone, when pulmonary lesions have complicated the case. It is remarkable to see with what promptness the cough subsides after the necrosed bone has been removed.

Case 2.—Capt. N., æt. fifty-nine, came to the hospital December 14, to receive treatment for ancient fracture of the left arm. The history of the case is as follows: In 1864, at the battle of Dallas, Ga., he was shot through both thighs. On account of the resulting disability he fell in 1865, and fractured the surgical neck of the left humerus. From this there remained a disability of the shoulder joint. In 1873 he again fell, sustaining an oblique fracture of the middle third of the left humerus. This fracture was never properly adjusted, and united with a slight twist of the axis, and a shortening of three-fourths of an inch. In 1875 he received another fall, breaking both bones of the left fore-arm. The radius was fractured just above the insertion of the pronator radii Teres, and the ulna one-half inch above this. In 1883 he received his last fall, sustaining an injury of the left fore-arm in the form of a *Colles'* fracture of the radius, a dislocation forward of the ulna, and a fracture of the ulna one-half inch above the articulation.

He came to our clinic to obtain relief from a constant pain which had troubled him more or less since the first injury of the fore-arm, and which, after the last fracture, had become almost unendurable.

Upon examination we found the fore-arm very crooked. The upper fracture of the radius and ulna had apparently never been adjusted and had united at an angle of 50° inclining toward the radial side. The upper fragment of the radius was supined outward, the lower fragment was pronated and its upper end was resting against the ulna, to which it was firmly anchored. The last fracture of the radius had a vicious union. The ulna had never been reduced and the short lower fragment was united at an oblique angle outward and the lower end of the upper fragment was united to the radius. This gave the whole fore-arm a peculiar or tortuous appearance.

At this time he had no use of the arm and was supporting it in a sling with the fore-arm embraced in a leather splint. The pain was evidently neuralgic and was occasioned by the impingement upon both radial and ulnar nerves. He had been advised by good army surgeons to have the arm amputated as the only means of relief. This he was not willing to undertake so long as other remedies were available.

It was for this purpose that we operated December 20 in the following manner: An incision was made along the margin of the ulna over the upper and lower points of fracture and a corresponding incision was made along the margin of the radial line to cover the same points of fracture. Dis-

secting away the soft parts we found the exact position of the fragments as above described. With Hayes' saw we severed the radius nearly at a right angle at the point of fracture. The lower fragment was then pried away and separated from the ulna. At the seat of *Colles'* fracture the ligamentous union was cut out and the lower end of the ulna was separated from the radius by means of a chisel. At the point of the upper fracture in the ulna we took out a V shaped section from without inwards, the base of which was one inch in length. This enabled us to bring the ulna into a straight line corresponding with the radius. At the seat of the lower fracture of the ulna the bones were separated by means of the bone forceps and the lower fragment was put into line with the upper fragment. Now having separated all union between the bones and perfected the radial and ulnar lines, the whole fore-arm and hand were embraced in a long dorsal and a short anterior or interosseous splint.

Several extensive abscesses formed but were readily evacuated. After ten weeks of careful management he left the hospital a happy man. The tormenting pain from which he had so long suffered was entirely relieved. Natural sensation had been restored to all the fingers and he was enabled to manipulate them with freedom. He still wore the long dorsal splint and we advised its continuance until the arm became perfectly firm and solid. Firm union had taken place in both radius and ulna at the upper fracture and the lower fracture of the ulna, but it was not then complete at the seat of *Colles'* fracture. Reports since leaving the hospital show that the arm is doing well, growing stronger and becoming more and more useful.

Case 3.—Mrs. D——, æt. thirty-four came to the hospital May 5, 1886. For a year previous to this time she had been treated for lumbar and sacral neuralgia. This had caused her much suffering and her general health was greatly impaired. About six weeks before coming to the hospital she discovered a small tumor in the inguinal region. This had increased in size until the time of our examination, when it nearly filled the inguinal space. It was fluctuating, and upon being opened by a valvular incision, discharged a quart or more of greenish white pus. A drainage tube being inserted, it was frequently irrigated with carbolized water, and the patient received *phenic acid* and *arsenicum* as internal remedies.

During her stay of six weeks she suffered from absorption, and her general condition was much impaired. June 15 she left the hospital and went to her home. At this time there was only a slight discharge from the abscess, and the drainage tube had been removed.

The object in reporting this case is to show the importance of accurate diagnosis, without which no treatment can be fully successful. Here is a case which had been treated solely as a neurotic subject without relief. Subsequent history proved it to be an inflammatory trouble which—if proper measures had been instituted in its early history—might possibly have been prevented from passing on to the stage of suppuration.

It is not an infrequent occurrence that morbus coxarius in its earliest stages is mistaken for rheumatism of the knee or leg, and treated as such for many months until inflammation has done its work and an abscess is formed in the cotyloid cavity.

So we might mention many surgical diseases which are improperly treated, owing to mistaken diagnosis.

Case 4.—I was first called to see Mrs. H. in 1878, when I learned that for four years previous she had suffered with what had been called bilious attacks, recurring at intervals of three to five months. At such times she would be seized with violent pain in the left hypochondriac region, which was attended with retching and vomiting. Her relief had been obtained by taking powerful cathartics to open the bowels, and morphine to allay the pain. These attacks would last only two or three days, when she would regain comparatively good health until their recurrence.

Upon examination I found an oblong tumor in the region of the splenic flexure of the colon which was movable, and would recede beneath the ribs. To the sense of touch it was hard and firm, and was attended with slight tenderness at the time of these attacks. Her mode of living was simple, but she suffered from constipation.

I placed her under the influence of Nux vomica which seemed to relieve the gastric symptoms somewhat. The tumor remained but did not change much in size or form. I was now confident that her distress had some relation to this enlargement though I could not satisfy myself in regard to its nature. The very low position which it would sometimes oc-

cupy, together with its form and size, had led some to believe it to be a dislocated kidney. Urinary analysis gave us no information.

For six months she was continued under the influence of Nux vomica, Sulphur, Bryonia, Mercurius and other indicated remedies, with a view of alleviating the constipation and recurrence of the pain. She was finally given Nascent Phenic Acid internally and hypodermically. This was faithfully continued for some time. At the end of four weeks the bowels became regular and in three months the tumor had entirely disappeared. This led me to my first positive conclusion that the difficulty was connected with the colon.

For three years she continued to enjoy perfect immunity from pain and her bowels kept regular, Phenic Acid was discontinued at the end of six months.

Early in 1884 she began to suffer again with constipation and irritability of the stomach, for which she received treatment from different medical advisers at various times. Of their method of treatment I am entirely ignorant.

In December, 1884, she was seized with remittent gastric fever and general gastro enteric inflammation. This was afterward complicated with pyelo-nephritis which continued through the following January, February and March. During all this period her pain was paroxysmal, worse at certain hours of the day, and always aggravated if the bowels became constipated. Very little except the simplest liquid food was received by the stomach. The introduction of the slightest amount of food or even water would excite the most violent pain along the line of the descending colon and extended back into the renal district.

In the month of April her suffering was very much diminished and she removed from my district and went under the care of a neighboring physician. Several eminent medical men examined and prescribed for her during the summer and autumn of 1885. She gradually gained in strength but suffered more or less daily, and at times the paroxysms would be extreme.

In December, 1885, she again came under my charge and was suffering with the same symptoms previously mentioned. About a month later she was seized with a violent chill which was followed by remittent fever complicated with acute cystitis and general gastro-enteric inflammation. The same tenderness existed in the line of the descending colon and extended back into the renal district. At times it would seem like acute enteritis, then it would assume the form of acute neuralgia followed by symptoms which might indicate renal or vesical calculus.

In the following month (March) Dr. W. H. Burt, being called in consultation, was very confident that there was renal or vesical calculus. During my absence for a few weeks he had charge of the case when he dilated the urethra and made a vesical examination, finding, however, no calculus. His only hope for such a diagnosis was then centered in the kidney.

On the 4th of May, 1886, in the presence of Drs. Burt, Shears and Laning, we proceeded to make an examination by surgical exploration. Owing to the sanguine feelings of Dr. Burt and the many renal symptoms which had at times appeared, we made the usual incision for nephrotomy. Passing down to the renal capsule, it opened, the cellular and adipose tissue was divided and the entire body of the kidney was exposed. Externally it presented no abnormal appearance save a slight turgescence which deepened its natural color. The sense of touch revealed nothing. The exploring needle was freely used but detected nothing in the form of a calculus. The general appearance of the kidney did not warrant its removal.

The wound was closed, and the patient being placed in a supine position, an incision was made along the line of the colon extending from the front of the eleventh rib to the crest of the ilium. Pushing aside the omentum we found a hardened condition of the colon which seemed to be contracted for four or five inches and had a pronounced nodule in the region of the sigmoid flexure. The meso-colon was adherent to the abdominal artery, and this artery was drawn two and a half inches to the left of the mesian line. On account of this deviation the distinct pulsations of the artery, together with a slight vibrating sound, had led some physicians to apprehend an aneurism.

Inasmuch as the patient was in a very weakened condition at the beginning of the operation and having undergone an extensive exploration of the kidney, we were satisfied that her vitality would not admit of the section of the colon involved. For that reason we only liberated it from its adhesions and invaginated the stricture with the fingers, thereby enlarging the size of the canal. With little hope of her recovery, we closed the wound and dressed it antiseptically.

To the astonishment of all she rapidly recovered, both wounds healing without the slightest evidence of suppuration. In a few weeks she began to take food with relish and without discomfort. She gained rapidly in flesh, and for several months enjoyed perfect health and freedom from pain.

In December, 1886, she began to suffer with the same old pain, her stomach became irritable and her bowels were con-

stipated. In spite of all treatment her suffering continued and her stomach refused all aliment. The smallest amount of food would cause the most violent pain unless she was relieved by anodynes or anæsthetics. Life was sustained by taking drachm doses of olive oil and half-drachm doses of sulphuric ether. This was the largest quantity and the only thing the stomach would tolerate.

Seeing the desperate condition of our patient, and listening day after day to her appeals for another operation, we undertook the task March 30, 1887.

An oblique incision was made from a point opposite the border of the quadratus lumborum muscle, downward and forward in the direction of the external oblique, to the border of the rectus abdominalis. The omentum was found to be adherent to the peritoneal surface, and there were strong bands of fibrous adhesions to the small intestines. Near the sigmoid flexure, the small intestine was adherent to the colon. Its attachment at this point, together with its distension, led me to mistake a portion of the ileum for the descending colon. The adhesions were broken up and the wound closed.

The patient reacted nicely, and on the third day the stitches were removed, there being reunion of the parietes by first intention.

On the fourth day a dark and offensive discharge oozed from the drainage tube which had been placed in the abdominal cavity. There was the unmistakable odor of sphacelus. She was unable to take the least nourishment; there was general atony from inanition; paralysis of the organs of speech and deglutition followed, and she died Monday, April 4.

Within an hour after death, a post-mortem was held which revealed the cause of death. The transverse and the descending colon, including the sigmoid flexure, had undergone complete fibrous degeneration, and was reduced to the size and consistency of a bed cord. In many places the caliber was reduced almost to perfect occlusion.

The kidney was removed and found to be normal, with the exception of slight inflammatory action. The walls of the aorta were thickened but the caliber was not diminished except by its tortuous deviations caused by the adhesions.

Treatment of aneurism, with case.—By G. F. Shears, M. D.—The relative frequency of aneurisms as well as the serious results which follow their presence has made the con-

sideration of the subject an important one to earnest surgeons. From the earliest times the disease has been recognized and treated. For many years the cruel and unscientific plan of Celsus was followed. It consisted in laying open the tumor by a bold incision and after turning out the clots, applying the hot iron to the extremities of the divided artery. The results can easily be imagined. The patient either died from the hemorrhage at the time of the operation or fell a victim to the subsequent hemorrhage which followed the separation of the eschar. This procedure was succeeded by the plan of cutting down upon the tumor, clearing out the contents and ligating the artery above and below. The sac was then excised or destroyed by the process of suppuration. While an improvement on the preceding plan it was often followed by disastrous results, the patients died from imflammation, secondary hemorrhage or the subsequent amputation that was demanded. These radical and destructive methods were supplanted at the close of the last century by the operation first performed by the celebrated John Hunter, of tying the artery in the cardiac side of the tumor and some distance from the seat of trouble. The plan was strictly scientific for it recognized the fact that the artery is always diseased for some distance above the aneurism and therefore unable to hold a ligature sufficiently long for the vessel to become included. The Hunterian plan although a rational one was not always effectual and was followed by a large percentage of fatalities. According to Mr. Barwell, the records of six London hospitals showed a death rate of 23.08 per cent in the ligation for popliteal and lower femoral aneurism. Following the idea propounded by Hunter that a check to the circulation above the aneurism would obliterate the cavity of the sac it was early attempted to control the circulation by pressure applied upon the integument over the artery and between the aneurism and the heart. This procedure has of late years been very enthusiastically advocated as not only safe but comparatively free from pain and having the advantage if failure does take place. It does not preclude the possibility of resort to the ligature. The plan seems to have many advantages but it is not so simple in

execution as one would be led to believe, nor is it so free from pain or danger as it has been declared to be, as may be seen from the following.

Case—Mr. B. aged twenty-eight, farmer; two months ago while climbing a fence he strained himself just above his knee. The injury seemed to be increased by plowing and the exertion necessary to move the plows with his feet. He then thought he had rheumatism as he noticed a swelling at about the upper portion of the lower third of the right femur in the inner side. He consulted an allopathic physician who says he found at the lower third an aneurismal tumor the size of an orange. After consultation with several neighboring physicians it was decided to treat the tumor by instrumental pressure. The instrument consisted of an iron band sufficiently large to encircle the thigh at the middle third, to which was attached a concave plate to fit the posterior surface of the thigh, above anteriorly the band was pierced by a screw which terminated in an iron pad. This was arranged in such a manner that it could be screwed down upon the artery. Pressure was commenced on Tuesday and was continued most of the time until Saturday with the result, according to his physician's statement, of controlling the pulsations in the tumor. This condition remained for about a week when pulsation returned in the tumor and the foot became cold and dark.

Dr. Waggner of DeWitt was then called to take charge of the case and I was called in consultation. The patient then had a temperature of 100, pulse 103, no pain. The right leg from foot to knee was cold and dark and covered with watery blebs. On the inner and anterior side of the thigh extending from the knee to the middle of the thigh was a large diffuse swelling over which the skin was tense and of a dark color. Pulsation could be detected over the entire enlargement. A diagnosis of rupture of the aneurismal sac and resulting gangrene was made. Amputation was advised as the only chance of life. The recommendation was accepted and on the next day with the assistance of Dr. Waggner and son, the thigh was amputated at the middle third. Upon examination of the flaps the femoral vein was found to be inflamed and firmly filled with coagulated blood. The vein was then followed to the upper third of the thigh when it was found to be free. Amputation was made at this point. As the patient's history was bad, his father and brother having died from the shock of a slight injury, extensive preparations were made to overcome this condition should it take place during the operation.

The operation was made without any unusual depression and for a time the patient did well. When last seen twelve hours after the operation he was bright and cheerful but his pulse was faint. He died in twenty-four hours.

The femoral vein was followed on the amputated part as far as the knee and found to be occluded the entire extent. The artery was ruptured at its entrance into the Hunterian canal. Almost two quarts of coagulated blood had extravasated into the intermuscular spaces and around the bone.

That the fatality in this case, or at least the gangrenous condition which demanded amputation was due to the method of treatment, it seems to me, there can be no doubt. It may not be uninteresting in view of this case to review the different methods by which compression can be most effectually and most safely made.

Indirect pressure is applicable to most external and some internal aneuresims, and may be applied by the fingers or by some form of instrument. This pressure may be either gradual or rapid. By the former method is intended to partially occlude the artery so that only a small stream of blood can pass through the sac, and thus form layer by layer a laminated clot which will in due time fill up the aneurism. This method may be continuous or intermittent according to the power and endurance of the patient. By the rapid method the surgeon attempts to entirely close the vessels and to permit the formation of a clot in the aneurism and vessel by the sudden stagnation of the blood. For the purpose of making this pressure many instruments have been devised. That of Carte resembles very much the instrument described in this case related. Other surgeons have added several pads, so that pressure may be made upon more than one point, or that the pressure may be shifted. The time demanded for a cure varies; in some instances a few hours' compression has been sufficient, but in most instances when the pressure is gradual, days, weeks, and even months are required. When the rapid pressure plan is adopted the patient is usually given an anæsthetic, the circulation entirely controlled, and the pressure maintained continuously for several hours, until upon removal no pulsation is noticed in the tumor. Cures have been reported after two hours, and in other cases not until eighteen hours had elapsed. Digital compression is maintained by

the fingers of an assistant. One assistant presses the femoral artery against the pubic bone (in femoral aneurism) while a second watches the aneurism to detect any return in pulsation.

In order to economize muscular force a bag of shot may be hung in such a way as to press upon the finger and relieve the strain. Frequent changes of assistants must be made, as with all the aid of shots and weights the finger in a few minutes becomes too tired to compress the vessels. Whatever form of pressure is adopted it is essential that all pressure on the main vein be avoided, or a result similar to the one described is liable to follow. When the pressure is long continued great care must be taken of the skin at the point of pressure or ulceration may take place.

The statistics of compression do not lead one to take so rosy hued a view of the plan of treatment as one would be led to from the statements of some of its enthusiastic admirers. During a period of nine years Mr. Barwell collected from various American, British and Continental journals the reports of 148 cases of popliteal aneurism treated by pressure. According to these statistics, and the unsuccessful cases are, as a rule, less frequently reported than the successful ones, sixty-eight were successful and eighty were failures. Of the latter, six died from rupture of the sac, gangrene, and thrombosis and four suffered amputation. The cause of amputation was in two, ruptures of the sac, and in two, gangrene. Of these, one survived. Of twenty-nine cases of femoral aneurism reported by the same authority from London hospitals six were cured and four died. A comparison of these statistics with those given in the first part of this paper does not impress one with the very great advantage of this operation over the Hunterian method.

A CASE OF MISTAKEN DIAGNOSIS—By W. H. SWEETING, M. D., OF SAVANNAH, NEW YORK.—*Case*—Last fall I was called in consultation to see a patient who was complaining of trouble in his abdomen. He was about sixty-four years of age—a blacksmith by trade, and until within about five months of his death, which occurred soon after I saw him, he had continued to work at his calling.

His first symptom was pain in the umbilical region. The pain radiated in various directions. It was soon followed by nausea and distress after eating. The bowels became constipated. He began to lose flesh rapidly.

The symptoms that I have enumerated increased in severity so that he was confined to his bed.

About this time, say six weeeks before he died, a pulsating tumor was discovered, situated about two inches to the right of the umbilicus. It seemed larger than the clenched fist, and beat synchronously with the heart. I applied the stethoscope to it, and thought I distinctly heard a *bruit.*

When the patient was raised from a horizontal to a sitting posture he seemed greatly distressed for breath, and his heart palpitated violently.

On these symptoms a diagnosis of aneurism of the abdominal aorta was arrived at.

A noted allopath was afterward called in consultation, who disagreed with the diagnosis of his predecessor, and gave it as his opinion that the man was suffering from cancer of the stomach.

All of the physicians, four in number, who had had anything to do with the case met at the autopsy.

The thoracic cavity was first opened. The heart was found to be in a healthy condition, and the lungs likewise normal with the exception of some areas of hypostatic congestion in the posterior, inferior portions.

Next the abdominal cavity was explored, and the liver, stomach, spleen and kidneys were examined and found to be healthy. The descending aorta was then dissected out in quest of the aneurism, since the examination of the stomach had failed to locate the seat of trouble there. Surprising to part of the physicians present, the abdominal aorta was found in a perfectly normal condition; and the examination was likely to prove futile in determining the cause of death, when, in the cœliac axis where it divides into the gastric, hepatic and splenic arteries, an adventitions substance was discovered.

After cutting through the arterial walls and dissecting out the foreign body it proved to be of calcareous composition. It nearly occluded the passage, and in the opinion of the physicians present was a cause sufficient to produce death.

As to the genesis of this concretion nothing at the time of the examination was satisfactorily determined but subsequently it was learned that the man had received, a year or two previous to feeling pain and discomfort, a kick in the umbilical region from a vicious horse.

Dr. Gross says that "the exciting cause of the calcareous

transformation is chronic inflammation. The calcareous matter exists in various forms; sometimes in small grains or nodules, now in scales, plates or patches, and now in complete rings, which, encircling the vessel, convert it into a firm, rigid, inflexible tube." Dr. Gross further says that the earthy degeneration is most common in old subjects after the sixtieth year. It usually affects the aorta and its larger branches.

Under the head of atheroma Dr. Helmuth says, "a deposit of calcareous matter may take place in the coats of the vessel, and calcification or ossification ensue, which renders the tube brittle."

The case narrated would seem to come under the designation of calcareous degeneration of the coeliac axis.

No patches of calcareous matter were found in other parts of the arterial system. Therefore it is plausible to conclude that the kick received in the region where the deposit occurred was followed by inflammation, that became chronic; and calcareous transformation gradually took place, causing obstruction to the flow of blood through the gastric, hepatic and splenic arteries to the stomach, liver and spleen respectively, which in turn resulted in serious impairment of the functions of these organs, lowering the vital force from innutrition and finally causing death from exhaustion.

Hysteria in men.—Prof. Charcot's third volume on the diseases of the nervous system (*Lecons sur les maladies du Systeme Nerveux*), which has just been issued, a book of five hundred pages, is chiefly devoted to the forms of hysteria that occur in men. The idea is not a new one, but the illustrative cases that are given and the clinical analysis of the subject are replete with interest. Every physician of experience has met with cases of obscure and intractable nervous disease in men which deserve to be called hysterical whether the subject thereof has a womb or not. Everybody concerned will be glad to know that so eminent an authority has devoted his time, his talents and his remarkable opportunities to the study and differentiation of this class of cases.

A striking feature disclosed in the beginning of the work is that the subject of hysteria among men is not always or often the delicate, effeminate, fussy individual that we may have supposed. Nor is he one who is worn out with disease or debauchery. In the majority of cases Charcot finds him

to be a more solid and substantial character physically. The robust workman, full-chested, with large muscles, and accustomed to exposure, is the most fitting subject of this strange and diabolical disorder. It is not the dude or the dilettante pianist, the girlish boy or the old granny of the male persuasion, but the machinist, the blacksmith, the foundryman, the engineer whose hands are hard and hairy, that is most subject to the form of hysteria which is treated of in these lectures.

That hysteria is more common among men than has been generally supposed is shown by the facts cited in a thesis recently presented to the medical faculty of Paris, by M. Babinsky, in which 80 severe and 218 slighter cases are carefully reported.

But the most striking portion of Charcot's book is that in which he ranges the cases of "railway spine" in this category. For he insists that this intractable disorder is often hysterical, and the cases which are given in the text support the view very strongly. A collision occurs, or a passenger train is wrecked because the engineer, the brakeman or the switchman, or somebody concerned has taken a glass of bad whisky or a mug of beer, and the half crazy victims are herded together and taken care of in a wholesale way. The nervous system of each one has received a shock from which he has not quite recovered when his flesh-wounds have healed. Weeks, months and years will pass and the cicatrix, if there is one, remains a susceptible centre of morbid influence. Getting into court subsequently, or into the clutches of the lawyers, or into the cars to travel again, or even the reading of similar mishaps as they are heralded in the newspapers, all tend to perpetuate this form of accidental hysteria. So that for the safety and protection of corporations and of communities, which are so often and so outrageously imposed upon, there is need of a special class of experts who shall be versed in its detection.

This proposition will not be readily accepted, but its real value will be recognized as time runs on. For it is morally certain that a man or woman who has been spilled out of

a railway car, or rolled down an embankment, or fallen through a broken bridge, or been stunned by a collision while running at full speed, will have the nervous system in a more or less demoralized state forever afterward. And, even when the shock is not the sole cause of subsequent ill health, such an experience will almost certainly alter the clinical complexion of other and different diseases that may follow in the order of time.

Some of the cases given by the author are of striking interest and are worthy of note by the members of this Society:

A man of forty-four years, a merchant, strong and muscular, who had formerly been engaged in a wine-cellar and accustomed to handling barrels and casks of wine, had a curious history. His father had all his life been subject to a kind of nervous fits that were very trying for his family. One of his uncles and two of his cousins were epileptics. He himself had nine children, of which three were girls. One of the girls was an imbecile, and the two others were decidedly hysterical.

When this man was a child he was a great coward. He had the nightmare and was sometimes a somnambulist. Sometimes he would get up and go to his work while he was sound asleep. When he was about thirty-six years old he had his first accident, which came of cutting his fore-arm while testing the sharpness of his razor. The blood flowed and he was seized with trembling and soon lost consciousness, from which he could not be aroused for a long time.

Some time after this, while lowering a cask into a wine-vault, the rope broke suddenly and it got away from him and rolled with a crash to the bottom of the stairs. He had barely time to get out of the way. He was terribly frightened, but that did not prevent him from attending to the cask. Five minutes later, however, when he had gotten into the daylight he fainted. When he came to himself his legs trembled and he had to be taken home in a wagon. It became impossible for him to work. He could not sleep at night without dreaming of that accident, and always wakened with crying for help.

Ten days later he was seized with the first fit and was carried into the hospital, La Salpêtrière. Here the doctors found him in a paroxysm of decided hysteria. The whole of one side of his body was completely insensible, not only to the touch but to pinching, pricking and to heat. He was slightly deaf on the anæsthetic side, and the sight of the corresponding eye was also affected. His mental condition was unchanged. He was frightened; he could not sleep without dreaming of the old mishap; he did not want to be left alone

even in the daytime and he was very much afraid of rats and mice. He wearied himself with attempting to do a dozen things at the same time and finishing nothing.

He presented two sensitive points (*hysterogenes*), exactly like a hysterical woman, one of which was in either hypochondrium, and when pressure was made upon the skin over these points he was suddenly taken with a decided fit. As with women, his paroxysm began with a sense of choking, globus hystericus. Then followed singing in the ears, hissing sounds, and loss of consciousness. Then came bodily contortions, frothing at the mouth, and the protruding eyeballs became fixed, the breathing stopped, and all the voluntary muscles were contracted. This was the tonic stage of hystero epilepsy.

Then came relaxation and a brief period of repose; but suddenly he cried out, threw himself about, fell upon the bed and rebounded like a ball, which act was repeated several times without stopping. Finally, in the third stage, he had the passional attitudes and symptoms. The delirium set in and he had the wildest hallucinations; sometimes he thought himself in a forest pursued by a pack of hungry wolves, and again he was in the wine-vault in danger of being crushed by that falling cask.

This continued for some minutes when he awakened, looked at his arms and his body and seemed surprised to find that he had not actually been either bitten or crushed; recognized his attendants and spoke to them calmly. In a twinkling, however, he screamed again, had the same hysterical choking and the fit returned and went through the same stages as before.

One who has ever treated a woman with pronounced and decided hysteria, will recognize the identity between that affection and the trouble from which this poor fellow suffered. In his case as with the women, and as with the firemen spoken of by Putman & Walton, the disease originated in fright, or in a decided cerebral shock.

Another case was that of a laborer, a gilder thirty-two years old. He also was strong and robust, and as a child had been timid and addicted to sleep-walking. He would get up and go to work during the night while sleeping. He was intelligent and played upon the violin; but had abused himself and had suffered in consequence.

At twenty he had his first attack. While riding on the top of an omnibus he felt the epileptic aura and had barely time to descend before the fit came on. One evening while passing through a side street he was attacked by a tramp and robbed. In the scuffle he received a blow upon the head with

a knife which forced him to enter the hospital. Because of this brain-shock his fits became very frequent and he was admitted to La Salpétrière. There he became melancholy, remained in the corner aloof from the other patients, and did nothing all the day long. The whole of one side of his body was insensible, just as in the foregoing cases, and as we find it in women with confirmed hysteria.

He suffered almost incessantly in his head, and these sufferings were increased when he tried to read or to occupy himself with anything whatever. He also had the two hysterogenic points, by pressure upon which the hysterical paroxysm, or explosion, could be induced at will. The fit would begin as in other cases, with vertigo, ringing in the ears and throbbing in the temples. Then he would lose consciousness, writhe about, scream and throw himself from the bed, and finally become delirious and terrified and imagine himself pursued by night robbers, cut by a knife in their hands, and then awaken bathed in perspiration and broken down with fatigue.

These two cases and others that are given are typical and of great practical interest. Whether the idea that hysteria is less common, in its graver forms, among American than with Continental women, and more so among the men on this side of the Atlantic than upon the other, is really correct, may be doubted; but that different phases of this curious affection crop out very frequently among our male patients, is a matter of everyday observation. So that the old slander which holds that a mother-in-law is more likely to be disagreeable because she is hysterical, may also apply to not a few fathers-in-law of the unamiable sort.

As showing that this peculiar disease may be rooted in the alcoholic dyscrasia, the following case is of peculiar interest:

Not far from the bed of the gilder whose case is cited above, and in the same ward, lies a locksmith, who is twenty-seven years old. His father was an open drunkard. At about twelve years this patient became a poltroon, and was afraid to be left alone. He was, however, an excellent workman, and soon took some medals in the expositions. He was thrifty and made money, but was unfortunately addicted to drinking and to venereal excesses.

At the age of twenty-one, during a nocturnal excursion, he received a cut with a knife which put out the right eye. And this was the shock which applied the spark to the magazine. From that moment, whenever he went to sleep, he saw a hideous monster which was ready to attack him. On awakening the vision disappeared, but only to return when he slept

again, and this continued so as practically to deprive him of sleep. One day he was at work to fasten a balcony at the third story of a building, when he lost his equilibrium and fell, striking upon his feet. Two hours later, when he had become conscious, he found himself in one of the beds at the Hotel Dieu. He was not ill, but the shock was terrible. Fits of hysteria followed and he was forced to come to the Salpétrière. It was soon observed that like other confirmed hysterics, men and women, he had hemianæsthesia and certain zones of the skin the irritation of which caused the fits to recur.

The same conditions followed: rising in the throat, hissing and ringing in the ears, throbbing of the temples, etc. He would become unconscious, the epileptic period came with convulsive movements of the eye balls, the extremities stiffened and the fists were contorted and clenched. After this the clonic stage with violent jerkings, throwings of the body and rapid movements toward the ceiling with a rebound from the bed; and, finally, the delirium with hallucinations which, in his case, was not prolonged, and sometimes was lacking altogether, a condition which not unfrequently happens with women also.

These are examples of genuine hystero-epilepsy occurring in men, and, although the different and successive stages may not always occur so regularly or so perfectly, still it will be well for the American practitioner to be on the lookout for this strange disorder. We do not always find that the patient who suffers from malarial poisoning presents a perfect type of ague with its characteristic three-stage paroxysm in which the cold, the heat and the sweat are always in the same order of relation and succession. And if these clinical periods are shaken up, displaced or imperfect in some respects in so common a disease as intermittent fever, we surely could not expect better things of a purely neurotic disorder like hysteria. Another practical lesson is readily deducible from this portion of Charcot's book. The growing conviction is that, while the removal of the ovaries for various nervous and menstrual difficulties is the only known means of a radical cure, this operation is not always, or perhaps usually successful in cases of hystero-epilepsy. Until the present, no valid reason has been assigned for the fact; but, now that it is in evidence that a cerebral shock may cause this affection, not only in women but likewise in men, we shall begin to discriminate more carefully and to draw the line upon traumatic lesions of the ovaries and their associate organs. For there are some cases of hystero-epilepsy in women in which the ovary is the focal point and cause of the mischief, and for which there is

no known cure except by Battey's or Tait's operation, or by both of them combined. And there are similar cases in men in which an accidental lesion of the genitals might necessitate a resort to castration before the hysterical symptoms would be finally and forever disposed of and cured.

Our author is too bright and honest a man not to qualify his teaching, and so he tells us that men may have hysteria in the same mild and irregular forms as women do; that the attack is often induced by a slighter species of shock than in those already detailed; that the duration of the disease is often self-limited; that, although it is often accompanied by paralysis of sensation in an arm or leg, or both, or by other alarming symptoms, it frequently disappears spontaneously, leaving little or no evidence of its having existed.

In the matter of the "railway spine" his ideas are not so decidedly at variance with those of other writers, especially when he speaks of the effect of shock combined with structural lesions. He confines himself more particularly to the moral result of accidents that are not sufficient or suited to occasion such organic changes of the nervous tissue as the neurologist would naturally expect to find. Sudden alarm and agitation, terror and horror are the exciting causes which, in such as are predisposed, will induce the hysterical demoralization and tend to develop what he is the first to recognize as true hystero-epilepsy with its classical paroxysms, hemianæsthesia and the rest. In many cases the suffering that is induced by this form of concussion is real and unmistakable; but in others it is an echo of past pain, or a counterfeit that would deceive the very elect. Erichsen* clearly recognizes this condition:

"There is, in fact, that unconscious exaggeration of symptoms, and especially of pain, which is common to all hysterical people, that simulation or nervous mimicry of real disease which has been so well described by Brodie and by Paget. This state of things will last indefinitely without any very material change. There may be daily or weekly fluctuations, but the patient neither gets materially better nor worse. This state of things will continue, indeed, as long as the mind is impressed by the prospect of impending litigation. When once that has been removed, recovery, provided there be no organic complication, will take place so rapidly as to lead to the suspicion that the whole sufferings were purposely simulated, and that the patient was a malingerer. This conclusion may possibly be correct in some cases, but in others it is certainly unjust."

*On concussion of the spine, nervous shock and other obscure injuries of the nervous system, London, 1875, page 198.

Hospital Notes.

THE CLINIC ON NERVOUS DISEASES.

SERVICE OF PROF. H. B. FELLOWS.

LOCOMOTOR ATAXIA.—*Case* 15136.—Mr. O'L——, aged forty-five; occupation, clerk in postoffice, compelling him to stand ten hours a day; came to the clinic October 4, 1886. Five years ago he noticed "cramps" in his legs at night, which continued a year; this was followed by lancinating pains. During this time, in attempting to catch a street car, he found he could not run; had always been well and strong previous to this, and had been considered a good runner. He also complains of pain in bladder; difficult micturition, constipation and coldness of limbs, which are covered with cold perspiration.

On examination it was found that he could not stand steadily with his eyes closed, had vertigo when bending over, could not walk in the dark, but could walk long distances when he could see, without much fatigue; had numb feeling in feet with sensation as if walking over an uneven surface; sensation of weakness in limbs and lower part of back; no patella reflex; no trouble with larynx, eyes, nor stomach; is still at work, but does not stand. He was given Secale Cor. 3x, four times daily.

October 11.—Reports about the same. Secale 3x was continued.

November 1.—Reports great improvement, is stronger and can walk better; now carries a hod of coal up stairs, which he has not been able to do in some time. Secale 3x.

November 15.—Is still improving; he now reports that he had taken Ergot two years under old school treatment, with no benefit to himself. Secale 3x.

March 28, 1887.—Has had no medicine for two months, but reports improvement; is not yet able to walk with eyes

closed; still has pains in limbs, but not so frequent nor so severe; is less nervous. There is much less of the ataxy, and the most careful testing revealed no knee reflex. Secale 3x.

During April the report continues to be of improvement. The patient is much better, able to do his work, and is regaining more confidence in his legs.

MENIERE'S DISEASE.—*Case* 15154.—Dr. P—— came to the clinic February 12, 1887; has been deaf in left ear since he was a small child, does not remember whether it followed measles or scarlet fever; had a discharge from the ear for some time, for which a syringe was used occasionally, after which discharge disappeared. A few days before Christmas last he was taken suddenly with a pain in the left ear, with a feeling of uneasiness, and was obliged to give up work; after five days was able to return to business. At that time, however, he began being troubled with vertigo, which has increased steadily, so that now he is not able to walk without staggering; by keeping his eyes fixed on some object straight ahead he can walk fairly well. By placing a finger in the ear and moving it, there is a sensation as if moving the whole body, accompanied by vertigo. He was given Silicea 3x.

Some time after the above report the case reported continued improvement, no other remedy being used.

MENIERE'S DISEASE.—*Case* 15164.—Mr. M——, aged sixty, came to the clinic April 11, 1877. While at work seven weeks ago he was struck on the top of the head by a falling stone, causing unconsciousness for two days, followed by vertigo and noises in the ear; he was confined to his bed about a week, after which he noticed that he was partially deaf in the left ear; he also complains of noises in ear, sometimes sharp and shrill, oftener deep and heavy. He has vertigo, falls forward and to the left, cannot walk in a straight line; he is worse at night, but has no vertigo when lying down. His deafness is increasing. Has good knee reflex. He was given Silicea 6x, four times daily.

April 18.—Reports great improvement; noises in ear diminished and can walk better. Silicea 6x continued.

Miscellaneous Items.

The Post-Graduate course, now in progress, is a decided success.——Prof. Vilas has returned from California.——Dr. H. V. Halbert, '87, is associated with Prof. Hall, and therefore remains in Chicago.——Dr. E. M. P. Ludlam has changed his residence to 397 W. Monroe St.——The Inaugural Address of the President, Dr. Walter Y. Cowl, before the New York Society for Medico-Scientific Investigation, an excellent production, is out in pamphlet form.——Dr. P. B. Hoyt, our much esteemed friend, died of apoplexy at the age of sixty-two, in Mankato, Minn., quite recently.——The Wisconsin State Homœopathic Society meets in Waukesha, June 22 and 23.——Dr. Hayward's "Taking Cold" the cause of half our diseases, is out in a seventh edition.——Diseases of the Lungs and Pleuræ, including Consumption; and Diseases of the Blood and Nutrition, and infectious diseases, constitute Vols. XI and XII of Wood's Library, both of which are valuable works.——One of our correspondents insists that Philadelphia has gone over to the gynecologists because he observed that each little spire on the new court house was embellished with a nicely gilded pessary stem.——We cannot too highly praise the Cyclopædia of Drug Pathogenesy, which is being edited by Drs. Richard Hughes and J. P. Dake. Part V, *Cantharis-Chromium*, is out, and the work is of exceeding interest and value——Dr. Geo. E. Bushnell, formerly house physician of the Hahnemann Hospital, has located in St. Paul, Minn., and Dr. Elizabeth Avery, at 315 Lincoln Avenue, Chicago.——Dr. F. L. Vincent, of Troy, N. Y., has accepted a position on the medical staff of the Clifton, Springs, N. Y., Sanitarium.——The Western Academy and the Nebraska State Homœopathic Society will have a joint meeting in Omaha, May 25–27.——President Ormes and the proper authorities are arranging for a great gathering of the members of the American Institute in June. Hurrah for Saratoga!